Washington's Health Home SPA
7/22/2013

SUBMISSION SUMMARY

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Executive Summary

Under Washington State's approach, health homes are the bridge to integrate care within existing care systems. A health home is the central point for directing patient-centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up; and improving patient outcomes by mobilizing and coordinating primary medical, specialist, behavioral health and long-term care services and supports. Care Coordinators must be embedded in community based settings to effectively manage the full breadth of beneficiary needs.

Washington has four high level goals to assess the effectiveness of their health home program - 1) Improve the beneficiary's clinical outcomes and experience of care; 2) Improve the beneficiary's self-management abilities; 3) Improve health care quality and

promote efficient and evidence-based health care service delivery; and 4) Reduce future cost trends or at the very least attain cost neutrality with improved outcomes.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	**2013**	**$1077000.00**
Second Year	**2014**	**$7771000.00**

FEDERAL STATUTE/REGULATION CITATION

Affordable Care Act, Section 2703, Section 1945

SUBMISSION - PUBLIC NOTICE

Date of Publication – 04/02/2013

OTHER METHOD

Beneficiary Focus Groups: In October and November 2011, meetings were held with a total of 135 beneficiaries who receive services from both Medicare and Medicaid to discuss their experience in accessing, navigating and receiving services paid for by these two fund sources. Participating beneficiaries represented diverse characteristics across age, ethnicity, race, disability and rural and urban settings. Beneficiaries participating included those who have experienced issues related to homelessness, mental health and recovery, substance abuse, multiple chronic conditions or disabilities and they received a broad array of services. Groups were held throughout the state in both urban and rural locations. Participants were asked to discuss from their perspective what works well in the delivery of their services, what doesn't work well, who they go to when they need help, and what the state can do differently to help them access services.

Engagement forums: Stakeholder Engagement Forums were held in September 2011 in Lacey, Everett, Yakima and Spokane. In response to invitations to beneficiaries, their families, advocates and providers the forums had 112 participants. Those sessions

were iterative and provided attendees the opportunity to discuss and provide input on the key components of an integrated system and consumer protections. As the forums evolved, performance and evaluation measures were explored.

Access - Summarize Comments: Lack of available providers and the short time allotted for provider visits, as well as the lack of coordination between providers, contributed to challenges in navigating the system. These challenges are magnified when having to navigate multiple systems.

Summarize Response: Comments were organized into categories and considered during design period.

Quality – Summarize Comments: Individual beneficiaries have different needs, and that the needs of specific individuals are likely to increase or decrease over a period of time. They noted that any system needs to recognize these differences, allocate limited resources accordingly, and be responsive to individuals transitioning between services and supports as needs vary. For example – while multidisciplinary teams were seen as a key tool for coordination and decision making, participants indicated that not all dual beneficiaries would need such a team.

Summarize Response: Comments were organized into categories and considered during design period.

Service Delivery – Summarize Comments: Many beneficiaries report difficulty in keeping track of the array of workers in each of the service systems they deal with and confusion over the roles and responsibilities of providers/staff within each of these systems. Several reported giving up on the system and only attempting to access care when it is urgent or a crisis. In addition, a number of beneficiaries expressed concern over the inflexibility of the delivery system, specifically in the responsiveness to health variability and a recognition that people's needs vary and shift and that a "one size" approach to care does not address these needs.

Summarize Response: Comments were organized into categories and considered during design period.

SUBMISSION – TRIBAL INPUT

Date of Publication – 02/14/2013

SUBMISSION – SAMHSA CONSULTATION

Date of consultation – 07/06/2012 & 11/08/2012

HEALTH HOMES POPULATION CRITERIA AND ENROLLMENT

Population Criteria

One chronic condition and at risk of developing another

List of chronic conditions: Mental Health Condition, Substance Use Disorder, Asthma, Diabetes, Heart Disease,
Others: cancer, cerebrovascular disease, coronary artery disease, dementia or Alzheimer's disease, intellectual disability or disease, HIV/AIDS, renal failure, chronic respiratory conditions, neurological disease, gastrointestinal, hematological and musculoskeletal conditions.

Specify the at risk of developing another chronic condition: At risk of a second is a minimum predictive risk score of 1.5. The predictive risk score of 1.5 means a beneficiary's expected future medical expenditures is expected to be 50% greater than the base reference group, the WA SSI disabled population. The WA risk score is based on the Chronic Illness & Disability Payment System and Medicaid-Rx risk groupers developed by Rick Kronick and Todd Gilmer at the University of California, San Diego, with risk weights normalized for the WA Medicaid population. Diagnoses, prescriptions, age and gender from the beneficiary's medical claims and eligibility history for the past 15 months (24 months for children) are analyzed, a risk score is calculated and chronic conditions checked across all categorically needy populations, and a clinical indicator (Y=qualifies; N=does not qualify) is loaded into the WA MMIS.

Potentially eligible beneficiaries with insufficient claims history may be referred to the program by contacting HCA. A tool has been developed to manually calculate risk. This tool will be on the Health Home website and distributed to the Designated Providers. Once a provider has determined a beneficiary is eligible by manually calculating their risk, that information will be sent to HCA for further analysis. If the beneficiary is eligible, they will be enrolled into a health home.

Geographic Limitations

By County - Pierce, Clark, Cowlitz, Klickitat, Skamania, Wahkiakum, Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima

Enrollment of Participants

Automatic Assignment with Opt-out

Describe the process used: The state will identify Fee-for-Service beneficiaries who are eligible for health homes based upon their chronic condition and risk score, and will enroll them into a Fee-for-Service qualified health home designated provider. Enrollment will be based on zip codes and capacity. The designated provider will assign health home beneficiaries to one of their network affiliated Care Coordination Organizations (CCO), who, in turn, will assign the beneficiary to a Care Coordinator. Beneficiaries have the ability to opt-out of the assigned health home or change enrollment to another designated provider or subcontracted Health Home CCO within the qualified provider network. Eligible beneficiaries who opt-out have the option of enrolling in a Health Home with a contracted designated provider at any time.

Managed care beneficiaries are auto-enrolled into a Medicaid managed care organization (MCO). MCOs qualified to be Health Homes or contracted with a Health Home will identify eligible beneficiaries based upon their chronic condition and risk score, and automatically enroll them into their Health Homes. The Health Home, in turn, will assign the beneficiary to a one of their network affiliated CCOs and a Care Coordinator. Beneficiaries have the ability to opt-out of the health home or change enrollment to another designated provider or subcontracted Health Home CCO within the qualified provider network.

Attestations:

1. The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.

2. The State provides assurance that eligible individuals will be given a free choice of Health Home providers.

3. The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Home services.

4. The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Home providers.

5. The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Home enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Home State Plan Amendment that makes Health Home services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.

6. The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

HEALTH HOME PROVIDERS

Types of Health Home Providers

Designated Providers:

1. Clinical Practices or Clinical Practice Groups
2. Rural Health Clinics
3. Community Health Centers
4. Community Mental Health Centers
5. Home Health Agencies
6. Community/Behavioral Health Agencies - Regional Support Networks:
7. Federally Qualified Health Centers (FQHCs)
8. MCOs
9. Hospitals
10. Substance Use Disorder Treatment providers

11. Case Management Agencies (Area Agencies on Aging)

Provider Qualifications and Standards:

1. Experience operating broad-based regional provider network;
2. Contracts directly with the state as a Qualified Health Home;
3. Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
4. Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
5. Subcontracts with CCOs to directly provide the Health Home care coordination services;
6. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
    a. Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or
    b. Optimizes beneficiary choice.
7. Maintains a list of CCOs and their assigned Health Home population.
8. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
9. Collects and reports encounters to the HCA;
10. Disburses payment to CCOs based upon encounters;
11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
12. Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

Primary Care Case Management:

Washington's PCCM model requires a primary care provider (PCP) to be responsible for coordinating the enrollee's care and is paid a monthly fee for doing so. Washington's PCCM program is only for American Indians/Alaska Natives, through contracts with tribal clinics, Urban Indian Clinics and Indian Health Service-administered clinics.

1. Contracts directly with the state as a Qualified Health Home;

2. Provides a toll-free line and customer service representatives to answer questions regarding Health Home and how to access services;
3. Subcontracts with CCOs to directly provide the Health Home care coordination services;
4. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
    a. Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or
    b. Optimizes beneficiary choice.
5. Maintains a list of CCOs and their assigned Health Home population.
6. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
7. Collects and reports encounters to the HCA;
8. Disburses payment to CCOs based upon encounters;
9. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
10. Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

Supports for Health Home Providers

Description of Methods that address the following:

1. **Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services,**
2. **Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,**
3. **Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,**
4. **Coordinate and provide access to mental health and substance abuse services,**
5. **Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,**

6. **Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,**
7. **Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,**
8. **Coordinate and provide access to long-term care supports and services,**
9. **Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services,**
10. **Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate,**
11. **Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.**

Description: The foundation of the State's health homes is the community network, which must be present in order to qualify as a Health Home. This ensures partnerships between mental health and substance abuse providers, long-term services and supports providers and the medical communities are developed to support care coordination and access through integrated health home services.

The beneficiary will be involved in improving their health through the development their Health Action Plan. Beneficiaries may choose to include their families and caregivers as part of their health home team.

Training of qualified health home designated/lead providers and Care Coordination Organizations will be sponsored between HCA and DSHS. DSHS nursing staff will develop a set of core curriculum materials for health homes to support the provision of timely, comprehensive, high-quality health homes services that are whole person focused. DSHS will offer technical assistance training for core skill building on relevant topics. Webinars, community network development meetings and/or learning collaborative will foster shared learning, information sharing and problem solving.

The State will provide access to PRISM, a secure web-based clinical support tool showing: the client's medical risk factors, demographics, eligibility, managed care status, housing, utilization of Medicaid and Medicare health services (inpatient, outpatient, ER, filled prescriptions, mental health services, long term care services and support, filled lab orders, dental), providers with contact information, long term care case manager assessments, patient activation measure assessments and completed health action plans. This resource will complement

existing clinic-specific Electronic Health Records, with information sharing facilitated by the State's developing Health Information Exchange. This provides the necessary foundation for a continuous quality improvement program.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services: The delivery of Washington's health home service model is based on an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for children and adults who meet Washington's defined chronic conditions and risk criteria. The integration of primary care, behavioral health services, and long term care services and supports are critical when improving health outcomes and reducing costs.

The Health Home qualification process will ensure the inclusion of ample designated providers, such as managed care organizations (MCOs), hospitals, Federally Qualified Health Centers (FQHC), Regional Support Networks, Area Agencies on Aging, Community Mental Health Agencies, Substance Use Disorder Treatment Providers, Specialty Care and Primary Care Providers, and Tribal Clinics.

The purpose of qualifying Health Homes is to provide HCA with geographically based qualified Health Home providers, who through their respective networks, provide intensive Health Home care coordination services to Medicaid and Medicare/Medicare beneficiaries with chronic conditions to ensure that services delivered are integrated and coordinated across medical, mental health, chemical dependency and long term services and supports. Beneficiaries who are eligible for Health Homes receive direct services from HCA and DSHS, but the Health Home contracts are based in HCA.

Additionally, multidisciplinary team members will be recruited to support clinical decisions and evidenced-based care. Multidisciplinary team members will be composed of willing participants who provide direct service to the beneficiary or subject matter experts, such as primary care providers, mental health professionals, chemical dependency treatment providers, social workers, nutritionists/dieticians, direct care workers, pharmacists, peer specialists, family members or housing representatives.

The Health Home structure is built on the following hierarchy:

1. Designated Provider/Lead Entity - Healthcare systems, providers and authorizing entities with experience developing community based service provider network relationships, such as managed care organizations (MCOs), hospitals, Federally Qualified Health Centers (FQHC), Regional Support Networks, Area Agencies on Aging, Community Mental Health Agencies, Substance Use Disorder Treatment

providers, Specialty Care and Primary Care Providers. The Designated Provider contracts directly with the state and is responsible for service delivery model and administration of the Health Home. Lead entities collect and submit encounters; disburse payment to network affiliated Care Coordination Organizations through the collection and submission of encounters, monitor quality; sub-contract; collect, analyze and report financial, health status and performance and outcome measures to objectively determine progress towards meeting overall Health Home goals; and provide customer service, such as toll-free lines or nursing advise lines.

2. Network Affiliated Care Coordination Organizations – Accountable for Care Coordination staffing and oversight of direct delivery of the six Health Home services. Care Coordination Organizations are responsible for implementing systematic processes and protocols to assure beneficiary access to Care Coordinators and care coordination functions. Care Coordination Organizations can be managed care organizations, hospitals, Federally Qualified Health Centers (FQHC), Regional Support Networks, Area Agencies on Aging, Community Mental Health Agencies, Substance Use Disorder Treatment providers, Home Health, Specialty providers, such as AIDS or ESRD clinics, Specialty Care and Primary Care Providers.

3. Care Coordinators – Operate under the direction of the Care Coordination Organizations by directly interacting with participating beneficiaries. Care Coordinators provide the six defined Health Home care coordination benefits in-person by actively engaging the beneficiary in developing a Health Action Plan; reinforcing the Health Action Plan and supporting the beneficiary to attain short and long term goals; coordinating with authorizing and prescribing entities as necessary to reinforce and support the beneficiary's health action goals; advocating, educating and supporting the beneficiary to attain and improve self-management skills; assuring the receipt of evidence-based care; supporting beneficiaries and families during discharge from hospital and institutional settings, including providing evidence-based transition planning; and accompanying the beneficiary to critical appointments when necessary. To better support beneficiary goals and ensure quality of care, they will coordinate services with authorizing entities for which the beneficiary is receiving services assistance. A Health Home Care Coordinator must provide service in the community in which the beneficiary resides so services can be provided in-person whenever needed, unless the beneficiary requests to receive their services elsewhere. Health Home Care Coordinators shall serve eligible individuals in the setting of the beneficiary's choice and may not establish policies that would restrict service because a beneficiary moves from one eligible setting to another. Care Coordinators must be clinical or non-clinical professionals, such as RNs, ARNPs, Psychiatric ARNPs, Social Workers, Mental Health Social Workers, Chemical Dependency Professionals, and Counselors.

4. Allied health care staff, such as community health workers, peer counselors or other non-clinical personnel provides administrative support for the Health Home Care Coordinator, such as mailing health promotion material, arranging for beneficiary transportation to appointments, and calling the beneficiary to facilitate face-to-face Health Home visits with the Care Coordinator.

5. Additional network providers who have agreed to participate in the health home model through the use of memorandums of agreement, subcontracts, or operational agreements. For example, a clinic may agree to provide referrals to a designated provider, through the use of an operational agreement.

Provider Standards

The State's minimum requirements and expectations for Health Home providers are as follows: Health home providers/networks will be developed to meet the needs of the population. Care coordination should occur across service domains and therefore include many different disciplines. A health home is qualified by the State and is responsible for the integration and coordination of primary, acute, behavioral health (mental health and substance use disorder) and long-term services and supports for high cost/risk persons with chronic illness across the lifespan through contractual/operational arrangements with appropriate providers. A health home is the central point of contact working with the managed care or fee-for-service beneficiary to direct person -centered health action planning and implementation and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes by addressing health care needs.

Washington is in the process of "qualifying" the health home delivery system through a competitive Request for Application (RFA) for each region of implementation. The first RFA application was released on November 26, 2012. The second RFA was released on February 24, 2013. Proposals are scored on the following:

1. Minimum Qualifications – Applicant is a Medicaid provider in good standing, ability to serve 1,000 to 2,000 health home beneficiaries, experience operating broad based networks, agrees to serve the entire coverage area, assures 24 hours/seven days a week information and referrals, document beneficiary consent, subcontract with CCOs, ability to coordinate care and services after critical events, such as emergency department use and hospital inpatient admission and discharge, language access/translation capability, links to acute and outpatient medical, mental health and substance abuse services, links to community-based social services, including housing;

2. Provider Networks – must include authorizing entities, a wide-variety of Care Coordination organizations, such as CMHAs, Substance Abuse Treatment providers, long-term services and supports, FQHCs, Community Health Clinics, and PCCMs;

3. Organizational Infrastructure – ability to provide administrative functions, such as toll-free lines, customer service staff, policies on process and timelines for bringing in additional CCOs to preserve integrity of face-to-face health home care coordination activities, ability to track health home beneficiaries to CCO assignment, collecting and submitting claims and encounters, payment disbursement, taking into account intensity levels and/or movement between CCOs, quality monitoring, subcontracting, collecting, analyzing and reporting financial, health status and performance and outcome measures. Ability to ensure hospitals have procedures in place for referring health home eligible beneficiaries for enrollment if they are seeking or need treatment in a hospital emergency room;

4. Core Health Home Requirements – ability to provide six health home care coordination functions and guarantee of non-duplication of efforts, health action planning, self-management of chronic conditions, setting short and long-term goals, cultural competency, motivational interviewing, identification of services and gaps in services, evidence-based interventions, sharing information with beneficiary's treating/authorizing entities, establishing multidisciplinary teams, accompanying beneficiary to visits when requested, arranging for priority appointments, notification systems for transitional care, follow-up on medication upon discharge and follow-up with pharmacy to get scripts filled, help the beneficiary access follow-up care, referrals, optimizing social supports and family, use of health information technology; and

5. Center for Medicare and Medicaid Services (CMS) Health Home Provider Functional Requirements – descriptions of process used to ensure 11 core health requirements are met.

Additional points are awarded to Health Homes which include housing, charity organizations, shelters, and organizations that help with Medicaid eligibility even though the additional outreach services are not through designated providers. Scores are weighted with core health home requirements and network adequacy receiving the most points. Following the announcement of apparently successful bidders, debriefing and protest period, HCA and DSHS will conduct desk audits and on-site readiness reviews to ascertain readiness to provide Health Home services. Contracts will be offered after the readiness reviews.

The period of performance of any contract(s) resulting from the RFA is an initial two years. The start and end date of the two year period of performance is based upon the start date for each awarded contract. After two years, the program will be evaluated and based upon results may

be modified for quality. Other entities interested in applying as a Qualified Health Home will be invited to another Request for Application process, if more capacity is needed or there are gaps in care that would benefit from a more robust network.

HEALTH HOME SERVICE DELIVERY SYSTEMS

Fee for Service
PCCM – The PCCMs will be a designed provider or part of a team of health care professionals. The PCCM/Health Home providers will be paid based on the following payment methodology outlined in the payment methods section:

Other – description: PCCMs that contract with the Health Care Authority to provide Medicaid services to American Indians/Alaska Natives will be paid an additional service based enhancement (SBE) rate for Health Home Care Coordination. SBEs will be submitted as encounters to the state and paid on the three tiered rate levels for 1) Engagement, Participation and Health Action Plan; 2) Intensive Care Coordination services; 3) Maintenance Care Coordination services.

Requirements for the PCCM participating in a Health Home as a designed provider or part of a team of health care professionals will be different than those of a regular PCCM. If yes, describe how requirements will be different:
PCCMs who elect to become designated providers must contract with HCA and meet all the qualifications standards in the Request for Application (RFA). While PCCMs do not have to submit a proposal for the RFA, they do need to sign a health home contract to provide all the health home services in the manner dictated by the state. This means that PCCMs must have subcontracts in place with a wide range of Care Coodination Organizations that are staffed with care coordinators. Health Home care coordination services will be monitored to ensure non-duplication of services.

Risk Based Managed Care
The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals. Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Home services.

Contract language supports the requirement that all Medicaid health plans have to submit a proposal to become a Qualified Health Home through the Health Care Authority's Request for Applications (RFA); or subcontract with another Qualified Health Home to provide services to their Health Home eligible enrollees.

Contract language will contain:

1. Standards for the six Health Home services - Comprehensive Care Management, Care Coordination and Health Promotion, Transitional Care, Individual and Family Support, Referrals to the Community and Use of Health Information Technology;
2. The use of clinical and non-clinical care coordinators and support staff;
3. Contracts, memorandums of agreement or operational agreements with hospitals for ER notification and hospitalization, including a referral process to refer beneficiaries for health home services;
4. Standardized screening and assessments;
5. Development of a Health Action Plan through an in-person visit by directly interacting with the enrollee to promote self-management through the identification of short and long-term goals;
6. Process and outcome measures;
7. Encounter data reporting and tracking methods to document delivered services to support encounters;
8. The use of multidisciplinary care teams, that include the care coordinator, the beneficiary, and any other identified providers;
9. If the Health Home beneficiary is a Medicaid managed care enrollee, the MCO will share critical data with the Health Home Care Coordination Organization. Data may include institutional admissions and discharge readiness for transitional health care services management and facilitation, lapses in pharmaceutical payments that may indicate need for client outreach and education regarding medication use and over-use patterns, such as emergency room use that may suggest a need for a Care Coordinator visit or intervention to address the clinical and Health Action Plan goals.

Attestations:

1. The state provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.
2. The state intends to include the health homes payment in the health plan capitation rate.
3. The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:
    1. Any program changes based on the inclusion of Health Homes services in the health plan benefits
    2. Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)
    3. Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
    4. Any risk adjustments made by plan that may be different than overall risk adjustments
    5. How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM
4. The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.

5. The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.

PAYMENT

Fee for Service, Fee for Service Rates based on:

Other: Rates were built for three levels of payment using a clinical and non-clinical staffing model combined with monthly service intensity. Three levels of payment are dependent upon who is providing the services and the intensity of the service determined by in-person, one-on-one, high touch interactions. This first care coordination stage encompasses three primary responsibilities, in addition to the health home service: health screening and assessments, development of a health action plan for care management, and assess the beneficiary for self-management and promote self-management skills to improve functional or health status or prevent or slow declines in functioning. There is no withhold for this component of care coordination.

This is a one-time only rate and is triggered by the submission of a Health Action Plan encounter and the documentation of a health home service. This encounter must be submitted before any other encounter can be paid.

The second level is for Intensive Health Home Care Coordination. It is assumed that for each full -time employee (FTE), 50 clients can be supported. This rate is paid once per month, per beneficiary and is triggered by documenting delivery of a health home service.

The third level of payment is for Low-Level Health Home Care Coordination. This rate is paid once per month with an encounter. Low-level payment will be paid on a monthly basis, and payment is made only for months in which an encounter occurred. An encounter is represented by documenting delivery of a health home service. It is assumed that for months in which an encounter occurs, 2/3 will involve a phone call and 1/3 involves a home visit.

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Home provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

CMS regulations require that a health home service must be delivered before a payment can be made. Milliman adjusted the rates for the new set of Health Home care coordination activities and a new set of regulations by converted the staffing levels to a broader set of clinical and non-clinical staff, adjusting the percentages of time staff would be interacting with the beneficiary on a monthly basis, and averaging a defined set of in-person visits and telephonic contact. This methodology allowed for a more efficient calculation of the rates based upon the costs of a known model. A minimum level of activities was derived from averaging the amount of in-person visits and telephonic contact. The three rate levels derived from the analysis are:

1. The first PMPM for Health Homes, which includes Outreach, Engagement and Health Action Plan - $252.93
2. Intensive Health Home Care Coordination - $172.61
3. Low-level Health Home Care Coordination - $67.50

A portion of the rates were also defined for administrative functions and withholds. The administrative functions and withholds are part of the total rate as documented above:

1. Outreach, Engagement and Health Action Plan - $25.29,no withhold
2. Intensive Health Home Care Coordination - $17.26, $3.45
3. Low-level Health Home Care Coordination - $6.75, $1.35

This SPA does not make changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners.

Per Member, Per Month Rates. Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

The state developed a three-tiered rating system for the health home service delivery. Health Home encounters are submitted per member/per month. The initial tier of $252.93 is a once in a lifetime payment and the corresponding encounter must be submitted prior to subsequent payment for the other health home encounters. Policy guiding the decisions for rate tiers was based on efficiency of an automated process to reduce human error, economy of only paying for a service when a service is delivered, and quality by introducing a reduction in payment in the 2nd year of operation when performance expectations are not met.

The reimbursable units are $252.93 for the first tier, $172.61 for the 2nd tier and $67.50 for the 3rd tier. Cost assumptions include salary distribution, geographic distribution, and high-touch vs. low touch intensity of services. Providers must provide at least one health home service to claim reimbursement, with the expectation that high touch means in-person, face-to-face care coordination and low-touch means a combination of face-to-face or telephonic touch. All three tiers have a mix of clinical and nonclinical staffing elements.

The state will reconcile encounters with a monthly reconciliation report that includes: 1) Client ID; 2) Provider ID; 3) Date of Service; 4) identification of staff who provided the service; 5) amount and types of contact; 6) encounter transaction record; 7) date encounter was submitted; 8) date beneficiary disenrolled from the program or decided to not participate in the program.

The state will review the rates every two years through an actuarial analysis based upon experience data.

The agency's rates were set as of July 1, 2013 and are effective for services on or after that date. All rates are published on http://www.hca.wa.gov/Pages/health_homes. aspx. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Incentive payment reimbursement. Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

The state will pay the entire rate for the first year of the program. Policy directives on keeping the rates whole had three goals: 1) allow Health Homes to build their infrastructure and increase their capacity to provide health home services; 2) keep the withhold administratively simple; and 3) reward better performing health homes by reducing the withhold amount incrementally based upon performance measure results.

At the end of the 10th month of the first year of the program, the engagement rate for participation will be calculated using the following metrics:

Numerator – Number of beneficiaries assigned to the Designated Provider during the measurement period who had a paid encounter for "Outreach, Engagement and Health Action Plan," regardless of who was paid for that encounter;

Denominator – Number of beneficiaries assigned to the Designated provider during the measurement period.

The 2nd year withholds will be applied to the Intensive Health Home Care Coordination rate of $172.61 per member/per month and the Low-level Health Home Care Coordination rate of $67.50 per month with an encounter.

1. 45% or higher participation rates will guarantee full payment of the rates for another year, with no withhold applied;
2. Under 45% to 40% participation, a portion of the total withhold will be removed from the health home rate;
3. Under 39% to 30, a higher portion of the withhold will be removed from the rate, and
4. Under 30% the entire withhold amount of $3.45 will be removed from the Intensive Health Home of $172.61, reducing the rate to $169.16.

Low-Level Health Home Care Coordination
1. Same percents in 1 through 3 above, and
2. Under 30% the entire withhold amount of $1.35 will be removed from the Low-Level Health Home rate of $67.50 reducing the rate to $66.15.

Health homes who improve their results during the 2nd year, will have their rates adjusted back up to the total, based upon their engagement percentages.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.

Case management provided under the state's 1915(c) waivers is non-duplicative of health home services. The functions provided by 1915(c) case managers include determination of waiver eligibility, comprehensive assessment to determine unmet needs related to waiver services, service planning of services provided under the waiver, qualification of waiver providers, authorization of waiver services, and monitoring of service provision. This type of specialized case management for individuals receiving long term services and supports and developmental disabilities services will continue to be necessary for individuals served under waivers and health homes will not duplicate the functions provided by state and Area Agency on Aging staff that perform these functions.

Health Homes will be responsible for review of claims and social service use history, health screening (e.g., screening for common mental health conditions associated with chronic illness such as depression, patient activation assessments), examination of current clinical conditions and treatment, and PRISM application information. This assessment is used to identify care gaps, utilization patterns, where chronic care condition education and coaching may be most helpful and to assist the individual in development and implementation of their health care plan, including identification of self-care goals.

The health home will also be responsible for transitions, assessing individuals at higher risk for re-institutionalization and assisting the individual and their support network in gaining an understanding of discharge instructions and information, ensure appropriate follow-up primary and specialty care and that medication reconciliation occurs, and to assist with referrals for additional services the client may need.

Attestations:

1. The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule.

2. The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.

SUBMISSION - CATEGORIES OF INDIVIDUALS AND POPULATIONS PROVIDED HEALTH HOMES SERVICES

Category of Individuals – CN individuals

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Service Definitions – Provide the State's definitions of the following Health Home services and the specific activities performed under each service:

Comprehensive Care Management

Definition: Care Coordinators will deliver comprehensive care management, primarily in-person with periodic follow-up. Care management services include state approved screens, demonstrate the ability to provide continuity and coordination of care through in-person visits, and the ability to accompany beneficiaries to health care provider appointments, as needed. Care Coordinators assess beneficiary readiness for self-management and promote self-management skills so the beneficiary is better able to engage with health and service providers and support the achievement of self-directed, individualized health goals to attain recovery, improve functional or health status or prevent or slow declines in functioning. Comprehensive care management service delivery uses the Health Action Plan (HAP) as the beneficiary directed care management plan. The HAP is created during a face-to-face initial visit with the beneficiary and updated periodically every 4, 6 and 8 months. It is also updated when there are any changes in beneficiary circumstances such as hospitalization or ER visits. The results of screenings and assessments are captured via the HAP and used to identify gaps in care and chart the beneficiary's progress towards meeting goals through active participation in comprehensive care management.

Screens include clinical and functional screens, including depression, alcohol or substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual. Screens will support referrals to services when needed, e.g., referral for assessment of need for chemical dependency treatment, specialty care or long term services and supports. Other screens and assessments that may supplement comprehensive care management are mental health treatment plans, chemical dependency treatment plans, and/or other pre-existing care plans which include assessment results.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

All Health Home designated providers/lead entities will have access to the Medicaid Management Information System - ProviderOne (P1), the DSHS Predictive Risk Intelligence System (PRISM) and Insignia Health information technology sources. Authorizers and providers of long-term services and supports have access to the DSHS Comprehensive Assessment and Reporting Evaluation (CARE) data either electronically or in paper form. Data sharing agreements and Release of Information consent forms will be maintained by all Health Home Lead Entities to facilitate sharing electronic health information with their Health Home network affiliates.

1. DSHS is responsible for maintenance and updates to the CARE and PRISM.
2. Insignia Health is responsible through a DSHS licensing agreement for maintenance and updates to the Patient Activation Measure (PAM) and Caregiver Activation Measure (CAM) and administrative web site functions including Coaching for Activation.
3. HCA's P1 data system is responsible for Medicaid eligibility, enrollment, disenrollment, claims and per member per month (PMPM) payment to MCOs, payment of health homes, encounter data collection and reporting.
4. Emergency Department Information Exchange (EDIE) notification provides Medicaid claims data to ED physicians. EDIE is HIPAA compliant and can proactively alert care providers when high utilizing patients enter the ED through a variety of methods such as fax, phone, email, or integration with a facility's current EMR. Once notified, care providers can use EDIE to access care guidelines and crucial information on the patient from other participating facilities to better determine the patient's actual medical situation. A care management module is being developed for the EDIE system to facilitate defined treatment plans for frequent ED users in Washington State.

Scope of Benefit/Service. The benefit/service can only be provided by certain provider types.

1. Behavioral Health Professionals or Specialists:
   a. Psychologists licensed as a psychologist pursuant to chapter 18.83 RCW.
   b. Child psychiatrists licensed as a physician and surgeon in this state, who has had a graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.
   c. Psychiatric nurse is a registered nurse who has a bachelor's degree from an accredited college or university, and has had, in addition, at least two years experience in the direct treatment of mentally ill or emotionally disturbed persons, such

experience gained under the supervision of a mental health professional. "Psychiatric nurse" shall also mean any other registered nurse who has three years of such experience.

d. Counselor means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee.

2. Nurse Care Coordinators :
    a. Registered nurses licensed to practice registered nursing under chapter 18.79 RCW.
    b. Nurse Practitioners licensed to practice advanced registered nursing under chapter 18.79 RCW.
    c. Licensed Practical nurses licensed to practice practical nursing under chapter 18.79 RCW.
3. Nurses:
    a. Registered nurses licensed to practice registered nursing under chapter 18.79 RCW.
    b. Nurse Practitioners licensed to practice advanced registered nursing under chapter 18.79 RCW.
    c. Licensed Practical nurses licensed to practice practical nursing under chapter 18.79 RCW.
4. Physician Assistants- Must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent only under the supervision of a physician as defined in chapter 18.71 RCW and who is academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. Physician Assistants must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the NCCPA examination.
5. Social Workers - A master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary.
6. Chemical Dependency Professionals - Must be certified in chemical dependency counseling under chapter 18.205 RCW. Certification is through the Department of Health.

Care Coordination

The dedicated Health Home Care Coordinator shall play a central and active role in development and execution of cross-system care coordination to assist the beneficiary to access and navigate needed services. The Care Coordinator shall assure communication is fostered between the providers of care including the treating primary care provider and medical specialists and entities authorizing

behavioral health and long-term services and supports. Care Coordination is the bridge between all the beneficiary's systems of care, including non-clinical support such as food, housing, and transportation.

When providing intensive care coordination to the beneficiary, the Care Coordinator caseload will be maintained at a level that ensures fidelity in providing required health home services, including interventions. Community health workers, peer counselors or other non-clinical staff may be used to facilitate the work of the assigned Health Home Care Coordinator.

Care coordination shall provide informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors impacting a beneficiary's health and health care choices. Care Coordinators will promote:

1. Optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the Health Action Plan;
2. Outreach and engagement activities that support the beneficiary's participation in their care and promotes continuity of care;
3. Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes; and
4. Use of peer supports, support groups and self-care programs to increase the beneficiary's knowledge about their health care conditions and improve adherence to prescribed treatment.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

PRISM and Insignia Health are information technology sources that support the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services.

The Health Action Plan (HAP) may be shared via secure email or hard copy. The HAP includes:

1. Beneficiary and Care Coordinator prioritized action items;
2. Beneficiary identified goals (short and long term);
3. Action steps for the beneficiary, the Health Home Care Coordinator and/or other direct service and medical providers; and
4. If the beneficiary has a personal care worker, the HAP will include action steps for them to support identified health action goals identified by the beneficiary.

The HAP is updated and modified by the Health Home Care Coordinator quarterly, and as needed to support care transition. The HAP is also updated and modified as needed according to:

1. A change in the beneficiary's condition;
2. New immediate goals to be addressed through the Health Home; and
3. Resolution of goals or action steps.

Future HIT development includes addition of the HAP data elements to an electronic application.

The Health Home will promote the use of web-based health information technology registries and referral tracking systems.

Health Promotion

Health promotion begins for health home beneficiaries with the commencement of the Health Action Plan. Each Washington health home must demonstrate use of self-management, recovery and resiliency principles using person-identified supports including family members, and paid and unpaid caregivers. The Health Home Care Coordinator will use the beneficiary's activation score and level (1-4) to determine the coaching methodology for each beneficiary and develop a teaching and support plan. Educational materials are customized and introduced according to the beneficiary's readiness for change and progressed with a beneficiary's level of confidence and self-management abilities. Opportunities for mentoring and modeling communication with health care providers are provided through joint office visits and communications with health care providers by the beneficiary and the Health Home Care Coordinator. The health home will provide wellness and prevention education specific to the beneficiary's chronic conditions, Health Action Plan, including assessment of need and facilitation of receipt of routine preventive care, support for improving social connections to community networks and linking beneficiaries with resources that support a health promoting lifestyle. Linkages include but are not limited to resources for smoking prevention and cessation, substance use disorder treatment

and prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity, disease specific or chronic care management self-help resources, and other services, such as housing based on individual needs and preferences.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

Insignia Health is an information technology source and provides, in connection with the Patient Activation Measure (PAM)/Caregiver Activation Measures (CAM), the Coaching for Activation website. This site provides educational materials linked to a beneficiary's level of activation and can be sent electronically to a beneficiary or printed for review at a Home Visit or by phone.

PRISM contains the history of the PAM/CAM scores and responses for each survey administered to the beneficiary. The Health Home Care Coordinator is able to view the scores for each beneficiary alongside the medical, behavioral health claims and LTC services utilization and selected CARE characteristics (for those beneficiaries with long-term services and supports) so that education materials can be tailored to the individual's engagement and activation.

Comprehensive Transitional Care, (including appropriate follow-up, from inpatient to other settings)

Comprehensive transitional care shall be provided to prevent beneficiary avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, substance use disorder treatment or residential habilitation setting) and to ensure proper and timely follow-up care.

The beneficiary's Health Action Plan shall include transitional care planning. Transitional care planning includes:

1. A notification system with managed care plans, hospitals, nursing homes and residential/rehabilitation facilities to provide the health home prompt communication of a beneficiary's admission and/or discharge from an emergency room, inpatient, nursing home or residential/rehabilitation and if proper permissions, a substance use disorder treatment setting. Progress notes or a case file will document the notification and the Health Action Plan should be updated with transition planning.

2. The use of a Health Home Care Coordinator as an active participant in all phases of care transition; including discharge planning visits during hospitalizations or nursing home stays post hospital/institutional stay home visits and telephone calls.

3. Beneficiary education that supports discharge care needs including medication management, encouragement and intervention to assure follow-up appointments and self-management of their chronic or acute conditions, including information on when to seek medical care and emergency care. Involvement of formal or informal caregivers shall be facilitated when requested by the beneficiary.

4. A systematic follow-up protocol to assure timely access to follow-up care post discharge and to identify and re-engage beneficiaries that do not receive post discharge care.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

Emergency Department Information Exchange (EDIE) notification provides Medicaid claims data to ED physicians. EDIE is HIPAA compliant. EDIE can proactively alert care providers when high utilizing beneficiaries enter the ED through a variety of methods such as fax, phone, email, or integration with facility's current EMR. Once notified, care providers can use EDIE to access care guidelines and crucial information on the beneficiary from other participating facilities to better determine the beneficiary's actual medical situation.

Managed care organizations (MCOs) will notify Health Home Care Coordinators of beneficiary admission to hospital and tertiary care facilities to facilitate discharge planning and care transitions. MCOs will also inform the Health Home Care Coordinators of lapses in pharmacy refills for beneficiaries with chronic conditions requiring long-term use of medications. Health Home Care Coordinators are responsible for conducting outreach activities with the beneficiary to ensure medications have been picked up and are being used according to the clinical treatment plan.

Individual and family support, which includes authorized representatives

The Health Home Care Coordinator shall recognize the unique role the beneficiary may give family, identified decision makers and caregivers in assisting the beneficiary to access and navigate the health care and social service delivery system as well as support health action planning.

Peer supports, support groups, and self-management programs will be used by the Health Home Care Coordinator to increase beneficiary and caregiver's knowledge of the beneficiary's chronic conditions, promote the beneficiary's engagement and self-management capabilities and help the beneficiary improve adherence to their prescribed treatment.

The Health Home Care Coordinator and beneficiary shall:

1. Identify the role that families, informal supports and paid caregivers provide to achieve self-management and optimal levels of physical and cognitive function;
2. Educate and support self-management; self-help recovery and other resources necessary for the beneficiary, their family and their caregivers to support the beneficiary's individualized health action goals;
3. Discuss advance directives with beneficiaries and their families; and
4. Communicate and share information with individuals and their families and other caregivers with appropriate consideration of language, activation level, literacy and cultural preferences.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

PRISM software applications include the PRISM Health Report for selected beneficiaries. The PRISM report is provided to the beneficiary's primary care provider and any other health care provider identified by the beneficiary and supported by a signed release of information. This includes the Health Home Care Coordinator. The report includes:

1. Beneficiary demographics

2. Last dental appointment
3. Health conditions
4. Hospital stays
5. Emergency room visits
6. Office visits and procedures in the last 180 days, used by the Care Coordinator to assess sufficient clinical oversight of the client's chronic conditions
7. Prescriptions filled in the last 90 days
8. Prescriptions by drug class in last two years

Coaching for Activation educational materials are available electronically and are printed for beneficiary and family support.

Referral to community and social support services, if relevant

The Health Home Care Coordinator identifies available community based resources and actively manages referrals, assists the beneficiary in advocating for access to care, and engagement with community and social supports related to goal achievement documented in the Health Action Plan. When needed and not provided through other case management systems, the Health Home Care Coordinator provides assistance to obtain and maintain eligibility for health care services, disability benefits, housing, personal needs and legal services. These services are coordinated with appropriate departments of local, state and federal governments and community based organizations. Referral to community and social support services includes long-term services and supports, mental health, substance use disorder and other community and social services support providers needed to support the beneficiary in support of health action goals.

The Health Home Care Coordinator shall document referrals to and access by the beneficiary of community based and other social support services.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

PRISM and Insignia Health are information technology sources supporting the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services.

Health Homes Patient Flow

Describe the patient flow through the State's Health Home system. The State must submit to CMS flow-charts of the typical process a Health Home individual would encounter:

Enrollment - based on chronic conditions and meeting the state's definition of "at risk for another" a clinical indicator (Y=qualifies) will be loaded into the WA MMIS. Beneficiaries with clinical indicators of "Y" will be enrolled into one of the qualified health home networks in the geographic region in which they reside. Outreach and education information will be generated by enrollment and sent from the State to the beneficiary by mail. The Health Home will receive the enrollment on a HIPAA compliant 837 and assign the beneficiary to one of their local Health Home Care Coordination Organizations (CCOs).

Beneficiaries may be referred to Health Homes by any health care provider. An example is a referral from a local emergency room department who has agreed with the Health Home to refer potentially eligible participants to the program.

Engagement - the assigned CCO places the beneficiaries with a Care Coordinator. The beneficiary is contacted and offered health home services. Once the beneficiary has agreed to participate in a Health Home, the CC prepopulates the Health Action Plan with PRISM claims utilization and arranges for an in-person visit. PRISM information includes episode information related to specific diagnoses or pharmacy utilization; inpatient and outpatient claims, emergency room visits and care, mental health claims, alcohol and other drug treatment claims, pharmacy claims and long-term care assessment data.

During the home visit, the CC:

1. Conducts a brief health screening including mental, physical and chemical dependency

2. Evaluates beneficiary's support system;
3. Completes a Consent for Release of Information;
4. Administers and scores the 13-question Patient Activation (PAM) or Caregiver Activation Measure (CAM; and
5. Introduces the Health Action Plan (HAP) to the beneficiary. Together, the CCO and beneficiary identify immediate and long-term goals, prioritize concerns and establish action steps.

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:

There is no generally accepted methodology for determining "avoidable" readmissions. We will use the CMS -defined specifications of Plan All-Cause 30 Day Readmissions required for the duals demonstration grant, adjusted for the health home population, unless a different metric is required by CMS. The current specifications:

Risk-adjusted percentage of participating health home clients who were readmitted to a hospital within 30 days following discharge from the hospital for an index admission.

Numerator: Risk-adjusted readmissions among participating health home clients at a non-Federal, short-stay, acute-care or critical access hospital, within 30 days of discharge from the index admission included in the denominator, and excluding planned readmissions.

Denominator: All hospitalizations among participating health home clients not related to medical treatment of cancer, primary psychiatric disease or rehabilitation care, fitting of prostheses, and adjustment devices for beneficiaries at non-Federal, short-stay acute care or critical access hospitals , where the beneficiary was continuously enrolled in Medicaid and health homes for at least 1 month after discharge, was not discharges to another acute-care hospital, was not discharged against medical advice, and was alive upon discharge and for 30 days post-discharge.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.

The State will calculate regional, risk adjusted, per member per month expenses in the target population in the baseline (FY2011), apply trend factors and estimate a projected per member per month figure. Cost savings will be calculated as the difference between actual and projected risk adjusted per member per month expenditures.

Describe how the State will use health information technology in providing Health Home services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

The State integrates fee-for-service claims data, managed care encounter data, eligibility, and enrollment data for medical, pharmacy, mental health, substance use disorder, long term services and supports, and Medicaid and dual eligible Medicare covered services in a secure web-based clinical decision support tool called PRISM. PRISM also pulls from other clinical assessment data within the state such as CARE. The State will use the PRISM tools to support the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, clinical protocols required and current utilization of case management, medical and behavioral health services. Use of these tools will enable the Health Home Care Coordinator to better coordinate care and ensure that the beneficiary's complex needs are met. Use of these tools will allow the State to monitor cost and utilization data to ensure program goals are met.

The State is currently planning to further develop HIT through OneHealthPort, an entity contracted with HCA to consult on building a statewide health information exchange. HCA will develop the Medicaid Health Profile clinical data repository, with clinical data passed through OneHealthPort HIE using the Continuity of Care Document (CCD) and the Admit/ Discharge/Transfer Document (ADT) transaction sets. Implementation will be phased in during 2013 and 2014.

Quality Measurement

Attestations:

1. The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.

2. The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.

3. The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.

Evaluation Description:				
Hospital Admissions	**Description**	**Measure Specification, including numerator and denominator**	**Data Source**	**Frequency of Data Collection**
	Focus will be on 30 day All Cause Readmissions	We will use the CMS Health Home defined specifications of Plan All-Cause 30 Day Readmissions unless a different metric is required by CMS: For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Numerator: Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination; Denominator: Count the number of Index Hospital Stays for each age, gender, and total combination.	ProviderOne (MMIS) claims and encounter data; Health Home enrollment data	Daily
Emergency Room Visits	**Description**	**Measure Specification, including numerator and denominator**	**Data Source**	**Frequency of Data Collection**
	Preventable/avoidable or treatable in a primary care setting ED visits	Focus on Preventable/avoidable or treatable in a primary care setting ED visits, consistent with the CMS-defined MFFS duals specifications: Based on lists of diagnoses developed by researchers at the New York University Center to Health and Public Service Research, this measure calculates the rate of ED use for conditions that are either preventable/avoidable, or treatable in a primary care setting (http://wagner.nyu.edu//chpsr/index.html?p=61)	ProviderOne (MMIS) claims and encounter data; Health Home enrollment data	Daily

		Numerator: Total number of ED visits with principal diagnoses defined in the NYU algorithm among demonstration-eligible enrollees; Denominator: Demonstration-eligible enrollees		
Skilled Nursing Facility Admissions	**Description**	**Measure Specification, including numerator and denominator**	**Data Source**	**Frequency of Data Collection**
	Skilled nursing facility placements	Focus on proportion of enrollees in skilled nursing facilities: Numerator: Number of demonstration-eligible enrollees who received institutional long term care services; Denominator: Number of demonstration-eligible enrollees.	ProviderOne (MMIS) claims and encounter data; Health Home enrollment data	Daily
Evaluations:				
Hospital Admission Rates	Hospital admissions are collected through claims data for admits provided under fee-for-service and through encounter data for admits provided under capitated managed care. Member month data collected from eligibility files.			
Chronic Disease Management	Diagnosis/procedure codes, pharmacy and service utilization collected from claims data for those services provided under fee-for-service and encounter data for those services provided under capitated managed care based on disease specific evidence based protocols.			
Coordination of Care for Individuals with Chronic Conditions	Chronic disease management data is collected through administration claims/encounter data, nurse care manager assessments, health home payment and health home encounter data verifying services received by clients (AOD treatment, mental health services, prescriptions, etc). This data is obtained through the State's MMIS payment system (ProviderOne). RN Care management notes and assessments provide evidence of interaction and referrals and will be evaluated at time of monitoring.			
Assessment of Program Implementation	Indicators of program implementation are collected from enrollment data, claims/encounter data, client assessment data and interim progress reports.			
Processes and Lessons Learned	The state has experience in implementation of opt-out and passive enrollment. The state will phase enrollment geographically to ensure ability to evaluate processes and apply lessons learned. Washington will use the HealthPath Washington Advisory Team (HAT) to collect input on implementation as well as to make recommendations on implementation strategies to ensure issues are addressed quickly and effectively. Process and lessons learned are collected through key informant interviews and interim progress reports.			
Assessment of Quality Improvements and Clinical Outcomes	Quality improvement indicators are collected from enrollment data, claims/encounter data, and client assessment data. As detailed in the quality measures section, Washington has identified a list of quality and outcomes measures that apply lessons learned from previous care management pilots that served high cost/high risk individuals. The outcome measures are intended to measure both quality and cost outcomes. Quality will be measured at multiple levels.			

Estimates of Cost Savings (if different from the method described under monitoring)	Information on cost savings comes from administrative claims/encounter data.